

may not exceed \$3.40 per visit. In succeeding years, any copayment may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with sections 1916(a)(3) and 1916(b)(3) of the Act and § 431.57 of this chapter, for non-emergency services furnished in a hospital emergency department, if the State establishes to the satisfaction of the Secretary that alternative sources of nonemergency, outpatient services are actually available and accessible to Medicaid beneficiaries in a timely manner.

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) *Institutional services.* For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of the payment the agency makes for the first day of care in the institution.

(d) *Cumulative maximum.* The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

[48 FR 5736, Jan. 8, 1983, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

§ 447.55 Standard co-payment.

(a) The plan may provide for a standard, or fixed, co-payment amount for any service.

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in § 447.54(a) and (c) to the agency's average or typical payment for that service. For example, if the agency's typical payment for pre-

scribed drugs is \$4 to \$5 per prescription, the agency might set a standard copayment of \$.60 per prescription. This standard copayment may be adjusted based on updated copayments as permitted under § 447.54(a)(3).

[43 FR 45253, Sept. 29, 1978, as amended at 73 FR 71851, Nov. 25, 2008; 75 FR 30262, May 28, 2010]

§ 447.56 Income-related charges.

Subject to the maximum allowable charges specified in § 447.54 (a) and (b), the plan may provide for income-related deductible, coinsurance or copayment charges. For example, an agency may impose a higher charge on medically needy beneficiaries than it imposes upon categorically needy beneficiaries.

§ 447.57 Restrictions on payments to providers.

(a) The plan must provide that the agency does not increase the payment it makes to any provider to offset uncollected amounts for deductibles, coinsurance, copayments or similar charges that the provider has waived or are uncollectible, except as permitted under paragraph (b) of this section.

(b) For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to offset uncollected deductible, coinsurance, copayment, or similar charges that are bad debts of providers.

(c) Payment under Medicaid due to an Indian health care provider or a health care provider through referral under contract health services for directly furnishing an item or service to an Indian may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deductible, copayment, cost sharing, or similar charge that otherwise would be due from the Indian.

[43 FR 45253, Sept. 29, 1978, as amended at 75 FR 30262, May 28, 2010]

§ 447.58 Payments to prepaid capitation organizations.

If the agency contracts with a prepaid capitation organization that does not impose the agency's deductibles, coinsurance, co-payments or similar

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charges on its beneficiary members, the plan must provide that the agency calculates its payments to the organization as if those cost sharing charges were collected.

[48 FR 5736, Jan. 8, 1983, as amended at 67 FR 41116, June 14, 2002]

FEDERAL FINANCIAL PARTICIPATION

§ 447.59 FFP: Conditions relating to cost sharing.

No FFP in the State's expenditures for services is available for—

(a) Any cost sharing amounts that beneficiaries should have paid as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charges under §§ 447.50 through 447.58 (except for amounts that the agency pays as bad debts of providers under § 447.57); and

(b) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium or enrollment fee.

§ 447.60 Cost-sharing requirements for services furnished by MCOs.

Contracts with MCOs must provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the requirements set forth in §§ 447.50 and 447.53 through 447.58 for cost-sharing charges imposed by the State agency.

[67 FR 41116, June 14, 2002]

ALTERNATIVE PREMIUMS AND COST SHARING UNDER SECTION 1916A

SOURCE: 73 FR 71851, Nov. 25, 2008, unless otherwise noted.

§ 447.62 Alternative premiums and cost sharing: Basis, purpose and scope.

(a) Section 1916A of the Act sets forth options for a State through a Medicaid State plan amendment to impose alternative premiums and cost sharing, which are premiums and cost sharing that are not subject to the limitations under section 1916 of the Act as described in §§ 447.51 through 447.56. For States that impose alternative premiums or cost sharing, §§ 447.64, 447.66, 447.68, 447.70, 447.71, 447.72, 447.74,

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§ 447.76, 447.78, 447.80, and 447.82 prescribe State plan requirements and options for alternative premiums and cost sharing for a group or groups of individuals (as specified by the State) for services or items (as specified by the State) and the standards and conditions under which States may impose them. The State may vary the premiums and cost sharing among groups of individuals or types of services or items, consistent with the limitations specified in this subpart and section 1916A(a)(1) of the Social Security Act. Otherwise, premiums and cost sharing must comply with the requirements described in §§ 447.50 through 447.60.

(b) Waivers of the limitations described in this subpart on deductions, cost sharing, and similar charges may be granted only in accordance with the provisions of section 1916(f) of the Act.

[75 FR 30262, May 28, 2010]

§ 447.64 Alternative premiums, enrollment fees, or similar fees: State plan requirements.

When a State imposes alternative premiums, enrollment fees, or similar fees on individuals, the State plan must describe the following:

(a) The group or groups of individuals that may be subject to the premiums, enrollment fees, or similar charges.

(b) The schedule of the premiums, enrollment fees, or similar fees imposed.

(c) The methodology used to determine family income for purposes of the limitations on premiums related to family income level that are described in § 447.78(c) of this chapter, including the period and periodicity of those determinations.

(d) The methodology used by the State to:

(1) Identify beneficiaries who are subject to premiums or cost sharing for specific items or services; and

(2) If the State adopts cost sharing rules that could place families at risk of reaching the total aggregate limit for premiums and cost sharing under Medicaid, defined at § 447.78, track beneficiaries' incurred premiums and cost sharing through a mechanism developed by the State that does not rely on beneficiaries, in order to inform